

State of California

Statement of Services Rendered

Send invoice to:

**BOARD OF PAROLE HEARINGS
P.O. BOX 4036
SACRAMENTO, CA 95812-4036**

PAROLEE/INMATE:

CDC Number:

Location & time of hearing:

Language Provided:

Type of Hearing: ☐ Lifer ☐ Revocation☐ Revocation Extension ☐ MDO ☐ SVP

Hours

[illegible]

I hereby certify that the hours, date of service and the description of the service rendered as set forth above are true and correct.

Total hours

Hourly rate

Total billing

Interpreter's (Signature)

Name _____

Address

City

State

Zip

S.S. Number / Certification Number (If Appropriate)

Date _____

DEPARTMENTAL APPROVAL:

Signature

Title

Date _____